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Office of Administrative Law Judges
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Issue Date: 22 May 2006

Case No: 2004-BLA-5814

In the Matter of

WANDA STEWART, Widow of
HARRY STEWART, JR., Deceased,

Claimant

v.

PEABODY COAL COMPANY,

Employer,

PEABODY INVESTMENTS,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

Sidney B. Douglass, Esquire
For the Claimant

Scott A. White, Esquire
For the Employer/Carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

On February 11, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. Wanda Stewart ("Claimant"), represented by counsel, appeared and testified at the formal hearing held on January 19, 2005, in Zanesville, Ohio. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had full opportunity to submit additional evidence and to present closing arguments or post-hearing briefs.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the miner had pneumoconiosis as defined by the Act and regulations;

2. whether the miner's pneumoconiosis arose out of coal mine employment;

3. whether the miner's death was due to pneumoconiosis; and

4. whether the regulations are constitutional.[1]

[1] The employer raises the issues of whether the new regulations are constitutional and whether they violate the Administrative Procedure Act. These challenges are beyond the authority of an administrative law judge, but are noted and preserved for appeal.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Harry Stewart, Jr. ("the miner"), Claimant's husband, was born on September 23, 1927 and died on January 24, 1997. (DX 3; DX 7). Claimant and the miner were married on January 28, 1956, and they resided together until the miner's death. (DX 6; Tr. 32). They had no children who were under eighteen or dependent upon them at the time this claim was filed. At the time she filed her application, Claimant resided in New Lexington, Ohio and had not remarried. (DX 3).

Claimant testified that her husband left coal mining in 1982 when his breathing became "so bad" that he could no longer "exert himself" or work. (Tr. 41). The miner actually quit working in the mines in January of 1982, but remained on the payroll and received disability payments for six months thereafter. (Tr. 41-42). He had worked in the mines all of his life since he was 16 years old, except for a two-year period when he served in Korea. (Tr. 33-34). All of his mining was underground, and he would come home each night covered with coal dust. (Tr. 33, 37). Claimant testified that his clothes would have so much coal dust in them that she could not put them in their washer, but would spray them off with a hose. (Tr. 37). His face would always be completely black and he would have coal dust in his ears and nose. (Tr. 37). The miner was told in 1972 that he had pulmonary problems. He then began to feel like he was smothering. (Tr. 38-40). His respiratory problems grew progressively worse. At one point in 1981, Claimant called an ambulance because her husband could not breathe in the shower and he was taken to the hospital and kept for treatment. Claimant testified that Dr. Haggenjos had been her husband's treating physician for approximately seventeen years and had seen him at least once a month during the last year of her husband's life. (Tr. 50). The miner took several medications for his respiratory ailments. (Tr. 57). In 1981, Dr. Haggenjos instructed the miner not to return to the mines. (Tr. 39).

The miner had great difficulty sleeping at night and used two pillows. Finally, in 1997, his physician prescribed oxygen at night but he was soon on oxygen continuously. (Tr. 43). In January of 1997, he collapsed at home, was transported to a clinic in Zanesville, placed on a ventilator and then taken by helicopter to Riverside Hospital in Columbus. The miner died while in the hospital, on January 24, 1997. (Tr. 47). Dr. Kander started treating the miner in 1991 for his heart condition and then treated him throughout his final stay at Riverside hospital, until his death.

Claimant testified that her husband smoked for approximately thirty-one years, staring in 1951 and quitting in 1982. She stated that he smoked less than a pack per day. (Tr. 51). Several doctors reported a smoking history of thirty pack-years.

The miner filed his first application for black lung benefits with the Social Security Administration in 1972. (DX 1). His claim was denied and he filed a subsequent claim for benefits on June 10, 1982. (DX 1). The miner requested a formal hearing and the claim was

transferred to the Office of Administrative Law Judges. However, in a Decision and Order issued July 29, 1985 the claim was denied. The Board affirmed the denial on April 20, 1988.

Claimant filed an application for survivor's benefits on December 4, 2002. (DX 3). The District Director issued a Proposed Decision and Order Awarding Benefits on December 9, 2003. Pursuant to the Employer's request for a formal hearing, the case was transferred to the Office of Administrative Law Judges on February 11, 2004. (DX 39).

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). The miner worked as a shuttle car operator and then as a foreman on the beltlines. (Tr. 25-26). On her application for benefits, Claimant reported that her husband worked in mining from 1943 to 1981 except for his time in the service. (DX 4). In his Proposed Decision and Order, the District Director found that the miner worked thirty-two years in coal mine employment. At the hearing, the parties stipulated to this length of time. (Tr. 35). The Employer's history of employment statement for the miner, a Social Security Earnings Statement and other employment records support the District Director's finding and the parties' stipulation. (DX 3-5). Therefore, I find that the miner worked for thirty-two years in underground coal mine employment. He last worked in the Nation's coal mines in 1981. (DX 4).

Medical Evidence and Surrounding Evidentiary Issues

Medical evidence submitted under a claim for benefits under the Act is subject to two different requirements. First, medical evidence must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. § 718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood gas studies, autopsies, biopsies, and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Secondly, medical evidence must comply with the limitations placed upon the development of medical evidence. 20 C.F.R. § 725.414. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports, and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy, or autopsy. § 725.414 (a)(2)(ii). Likewise, responsible operators and the District Director are subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i-iii).

At the hearing, the Employer indicated that he wished to "withdraw" Director's Exhibits DX 23 and DX 26, which are consulting medical opinions by Dr. Richard L. Naeye. The Employer's basis for this request was that it wanted to substitute as its designated evidence two other medical opinions, by Dr. Rosenberg (EX 1; EX 9) and by Dr. Renn (EX 3; EX 10), as listed on the Employer's Evidence Summary Form. However, I issued an Order post-hearing explaining that this evidence need not be withdrawn to comply with the evidentiary limitations, as I will only take into consideration the evidence designated on the parties' evidence summary forms. (Order issued March 15, 2006).

After my post-hearing Order was issued, the parties re-designated the evidence they wished to be considered and I find that these designations are within the current statutory limitations and in compliance with 20 C.F.R. § 725.414.

A. X-ray reports

Exhibit/ Offering Party	**Date of X-ray**	**Date of Reading**	**Physician/ Qualifications**	**Interpretation**
DX 1	10/25/84	11/27/84	Altmeyer/B[2]	0/0
DX 1	10/25/84	11/27/84	Renn/B	0/0

[2] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished). When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board has approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984).

B. Pulmonary Function Studies[3]

Exhibit/Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 1	Hillberg	54/68"	1.59	2.62	59	61	Yes	Good coop
DX 1	Daneshvari	57/68.5"	1.27 1.59*	3.05 2.52	54	83	Yes	-----

*denotes testing after administration of bronchodilator

C. Arterial Blood Gas Studies[4]

Exhibit	Date	Physician	pCO2	pO2	Resting/ Exercise
DX 1	10/25/84	Daneshvari	37 35*	104 118	Resting *Exercise

D. Narrative Medical Evidence

Dr. Nathan Howard Kander

The record includes several letters, treatment notes and progress reports by Dr. Nathan Kander, who treated the miner for his heart problems and other conditions from 1991 to his death in 1997. (DX 24). Claimant testified that Dr. Kander, who the record shows is board-certified in Internal Medicine and Cardiovascular Disease, saw her husband every day during his final hospitalization and was present at the time of his death. (Tr. 48). In 1991, Dr. Kander treated the miner for severe coronary artery disease and also reported severe pulmonary disease in the form of COPD (chronic obstructive pulmonary disease). Dr. Kander performed a catheterization that year. The miner was treated in 1993 for gall stones and strep and staph infections. In 1995, the miner was admitted to the hospital and treated for chest pain. That year, Dr. Kander performed an angioplasty and noted the miner's "severe lung disease" and "very severe underlying COPD." (EX 8). In a letter to Dr. John Caffaratti in April of 1995, Dr. Kander wrote that the patient had undergone a right and left heart catheterization. He added that

[3] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c) . The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in "substantial compliance" with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp*., 12 B.L.R. 1-27 (1988). The values from the FEV1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

[4] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).

the miner's shortness of breath was not related to his heart disease, but due to his "significant severe pulmonary disease."

On January 21, 1997, Dr. Kander wrote to Dr. Jerry Moore, describing the diagnostic angiogram and subsequent balloon angioplasty he performed on the miner. Dr. Kander noted that he would probably have a "very rocky hospitalization" due to the fact the patient was on a ventilator. His notes in 1997 also describe a heart catheterization and the miner's "possible coal mine disease." The post-procedure diagnosis included severe hypertensive heart disease, and severe coronary artery disease.

Dr. Kander was the physician who completed the miner's Death Certificate. He reported that the miner died on January 24, 1997 due to "severe chronic obstructive disease" that the patient had for "years" as a consequence of "coal miner's pneumoconiosis." This doctor listed "severe coronary artery disease" as another "significant condition" at the time of death.

On August 5, 1997, Dr. Kander provided the following opinion surrounding the miner's pulmonary condition:

> He unfortunately had a severe lung ailment with severe lung abnormality with what appeared to be a coal miner induced lung disease. He had severe emphysema, had smoked for several years and had worked in the coal mines for over 30 years. When I first saw him he had severe obstructive as well as restrictive lung disease on pulmonary function studies as well as severe coronary artery disease. He unfortunately required ventilator support in January of 1997 and was unable to be weaned from the ventilator because of his severe lung disease and I have no doubt that his prolonged exposure to coal dust was some of the cause for his severe lung disease.

On September 22, 2003, Dr. Kander wrote a letter "To Whom It May Concern," describing his treatment of the miner from 1991 to his death in 1997. This specialist believed the miner's disease was "quite severe" as shown by his low FEV_1 values and by the numerous breathing medications he was prescribed. Dr. Kander stated that the miner's thirty-two years in coal mining clearly contributed to his lung disease and "clearly" contributed to his demise. This physician explained that when the patient presented in 1997, he was placed on a ventilator, being found to have severe shortness of breath. Dr. Kander stated that, from a cardiac standpoint, the miner "remained reasonably stable, but unfortunately because of his severe lung disease, he was unable to be weaned from the ventilator" during his final hospitalization and subsequently passed away. Finally, Dr. Kander reported that his lung difficulties "contributed to his demise."

Dr. Jeffrey J. Haggenjos

The record contains several progress notes and a letter by Dr. Jeffrey J. Haggenjos, who Claimant testified was her husband's treating physician for about 17 years. (DX 25; EX 5; Tr. 50). This doctor's progress notes from March 1996 through the date of the miner's death in January of 1997 generally report on his recommendations and approval for the patient's home health care, as the miner could no longer function independently at that time. Care was ordered

throughout this period specifically because of the miner's "cardiovascular and cardio-respiratory problems," and his file includes reports that the miner was severely weak and dyspneic, and frequently suffered from lung congestion and exacerbations of his COPD. In April of 1996, Dr. Haggenjos noted the patient's severe COPD, unstable angina, hypertension and ulcer. He prescribed oxygen during the day and warned against any type of strenuous activity that may overload the miner cardiac or respiratory systems. In May of 1996, Dr. Haggenjos diagnosed chronic pulmonary fibrosis with emphysema and ordered the patient never to return to work. In July, he wrote another prescription for oxygen, along with a nebulizer and home hospital bed. In August of 1996, this doctor diagnosed severe obstructive lung disease and angina and ordered the patient's medication to continue as prescribed. This same treatment plan continued through December of 1996.

In a letter written on September 26, 2003, Dr. Haggenjos, Board-certified in General Practice, reported that he first examined the miner in 1979 and treated him until his death in 1997. Various conditions he treated included coryza, CAD (coronary artery disease), COPD (chronic obstructive pulmonary disease), coal miner's pneumoconiosis, hypertension, and arthritis. This doctor noted that Mr. Stewart was on oxygen "to maintain life." Dr. Haggenjos explained that the patient's COPD was "severe which was caused by 32 years of exposure to coal dust: and that the COPD "compromised his heart, blood pressure, and his cognitive functioning." In this doctor's opinion, pneumoconiosis "hastened Mr. Stewart's death." Dr. Haggenjos based his conclusions on his examinations, chest x-rays, and autopsy. (DX 25).

Dr. Joshua Perper

Dr. Perper, Board-certified in Anatomical, Surgical Pathology and Forensic Pathology, reviewed all medical reports, tests and opinions of record to the date of his consultative report on September 26, 2003, including the autopsy report and tissue slides. Based on this information, a 30-year coal mining history and a history of being a heavy smoker for several years, Dr. Perper diagnosed "significant CWP [coal workers' pneumoconiosis]" that he believed was a "significant contributing cause" of the miner's death. (DX 25; DX 28). Dr. Perper based his conclusions on several factors. First, he pointed out that the miner had worked for over thirty years in qualifying employment and that, according to specific studies cited in his report, the miner's chances for developing pneumoconiosis were significantly increased by his lengthy exposure to coal mine dust underground. Dr. Perper then referred to the patient's specific symptoms and medications prescribed over the course of several years and his eventual dependence on oxygen and inability to be weaned from a respirator prior to death. He then explained that radiographic studies often "miss" a diagnosis of pneumoconiosis or its severity, but that autopsy findings then clarify that the disease existed during miner's lifetime, as in the miner's case. This specialist then expanded upon the autopsy report, noting the presence of slight to moderate coal workers' pneumoconiosis as shown by macronodules in the lungs.

This doctor believed that the patient's exposure to coal dust contributed to his centrilobular emphysema. While recognizing that smoking typically leads to this type of pulmonary disease, Dr. Perper nevertheless believed, based on studies he cited in his report, that exposure to coal dust may play a "significant role" in the development of this particular disease. In his words, this scientific literature shows that coal dust exposure, alone, "and its related

emphysema complications have been shown to progress after cessation of exposure to coal dust (because of the entrapped and retained intrapulmonary fibrogenic crystalline silica)." Dr. Perper also pointed to other studies supporting the "widely and virtually universally accepted" causal connection between exposure to coal dust and silica in relationship to emphysema and chronic obstructive lung disease and noted the Department of Labor's recognition of this connection in its amended regulations. Dr. Perper then explained why he believed why the miner's pneumoconiosis hastened his death:

> Based on the clinical documentation of markedly abnormal respiratory symptoms and manifestations, the combined obstructive/restrictive pulmonary defects, severe hypoxemia, chronic and acute respiratory failure with need for supplemental oxygen and prior to his death, severe respiratory failure which made weaning from respirator impossible, as well as autopsy findings indicative of significant coal workers pneumoconiosis, with associated centriacinar (centrilobular emphysema) and his very long standing occupational history as a coal miner, as discussed above, it is my professional opinion within a reasonable degree of medical certainty that there is competent medical evidence that coal workers' pneumoconiosis was a significant contributory cause of death of Mr. Stewart, along with arteriosclerotic cardio-vascular and a hastening factor of his death, both directly and indirectly through:
>
> Director replacement of normal lung tissue by pneumoconiotic lesions and associated centrilobular chronic emphysema and resulting hypoxemia, which was also demonstrated clinically
>
> -The mechanism of death contributed by the presence of coal workers pneumoconiosis was through the following pathways:
>
> a. Direct pulmonary insufficiency and failure due to replacement of normally breathing lung by non-breathing pneumoconiotic tissues and associated centrilobular emphysema, and resulting hypoxemia.
> b. Through hypoxemia precipitating/aggravating a cardiac arrhythmia in an individual with heart disease
>
> As a matter of fact the scientific literature has substantiated such mechanism.

Dr. Perper then cites several pieces of medical literature and studies supporting the above statements. Dr. Perper's final Conclusions to this report were as follows:

1. The miner had evidence of significant coal workers' pneumoconiosis, causally associated with centrilobular emphysema.
2. The miner's coal workers' pneumoconiosis was a result of more than thirty-eight (38) years of occupational exposure as a coal miner to coal dust containing silica, a much more than sufficient exposure period necessary for developing coal workers' pneumoconiosis.
3. Coal workers' pneumoconiosis and the associated centrilobular emphysema, was a contributory cause of the miner's death both directly and indirectly

> through pulmonary insufficiency and through hypoxemia triggering or aggravating an arrhythmia, on the background of marked heart disease.

Dr. Perper attached Appendix 1 to his report, which is a seven-page outline of several studies supporting Dr. Perper's opinions and substantiating, in particular, his opinion that the miner's coal dust exposure was a contributing cause to his centrilobular chronic emphysema.

Dr. Everett F. Oesterling

The Employer submitted the reviewing medical report of Dr. Everett F. Oesterling, Board-certified in Anatomical and Clinical Pathology. (DX 19). Dr. Oesterling reviewed the autopsy report and slides. He attached to his report "photomicrographs" of the autopsy slides. This doctor noted the existence of black pigment in the lungs, but reported that this "anthracotic pigmentation of lung tissue is not truly a disease associated with dust deposition." In his opinion, the slides revealed a "limited dust exposure and ….very modest or minimal quantities of silica which would induce fibrosis were it present." Dr. Oesterling classified the miner's disease process as "anthracotic pigmentation with focal micronodular pleural change." He believed that the level of the disease he observed was "insufficient to have altered pulmonary function, therefore it produced no lifetime disability nor did it contribute to his death." Dr. Oesterling considered a forty to eighty pack-year smoking history, which he stated was "more than adequate to explain emphysema present." Moreover, considering the miner's age along with the patient's smoking history, Dr. Oesterling concluded that these two factors, alone, were the "etiologies of this gentleman's primary respiratory difficulties." Dr. Oesterling concluded that the miner did not have "coalmine dust induced disease" and that the "interstitium or functional component of the lung showed only a mild anthracotic pigmentation." He also noted that the "limited dust present was insufficient to have in any way produced respiratory or pulmonary impairment" and that pneumoconiosis "did not in any way contribute to this gentleman's coronary artery disease and therefore was not a contributing factor to his death." In Dr. Oesterling's opinion the "pulmonary component" present at the time of the miner's death was related to centribular emphysema associated with smoking. (DX 19).

On January 4, 2005, Dr. Oesterling was deposed surrounding his opinions reflected in his 2003 report. (EX 9). In his deposition, Dr. Oesterling discussed the method he used to examine and interpret the autopsy slides and repeated his finding of coal dust in the lung, revealed as black pigmentation. However, he noted that the black pigment was found only in the pleura, which he stated would not have affected the part of the lung that would have hindered the miner's breathing. Specifically, Dr. Oesterling did not think the coal dust he observed "altered his pulmonary functions" and was not "in any way a factor in shortening his life." He did find emphysema, but stated that coal mine dust had no impact on this condition. Dr. Oesterling also found no evidence of massive fibrosis, complicated pneumoconiosis, or cor pulmonale. In his opinion, the miner's death was not caused by pneumoconiosis and pneumoconiosis was "not a substantially contributing factor and did not hasten" the miner's death. Dr. Oesterling specifically disagreed with the report on the Death Certificate listing the primary cause of death as COPD. Instead, Dr. Oesterling believed the primary cause was the miner's cardiac disease. He also "totally" disagreed with the statement on the Death Certificate that pneumoconiosis was a contributing cause.

Dr. Oesterling explained that he did not see "enough" coal dust on the autopsy slides to "substantiate" a coal mining history of thirty-eight years, as reported, so he did not consider this length of history or mention it in his written report. He stated that he was "surprised" that he did not see more disease, given the miner's extensive smoking history combined with his reported coal mining history. Finally, Dr. Oesterling repeated his finding of a "very mild form" of coal workers' pneumoconiosis with "pulmonary anthracotic pigmentation." He believed the miner had a disabling cardiopulmonary condition.

Dr. David M. Rosenberg

The Employer also submitted a consultative report from Dr. David M. Rosenberg, Board-certified in Pulmonary Diseases, on April 13, 2004. (EX 1). Based on a coal mining history of thirty-two years, all medical records from 1982 through the date of the miner's death, the autopsy report, and a "long" smoking history, Dr. Rosenberg opined that the miner had "at most a minimal degree of simple coal workers' pneumoconiosis." Dr. Rosenberg did not review the autopsy slides. He believed that the miner's advanced centrilobular emphysema was not associated with the evidence of coal workers' pneumoconiosis and was not caused or contributed to by coal dust exposure. Dr. Rosenberg disagreed with the reliability of the studies referred to by Dr. Perper, supporting the proposition that the development of the miner's emphysema may have been related to coal dust exposure. He cited different studies refuting any such relationship unless complicated pneumoconiosis was present. Dr. Rosenberg then recited that the miner "obviously had severe COPD complicated by coronary insufficiency and coronary artery disease," and stated that the COPD was related to the miner's cigarette smoking. In his opinion, the miner's death "clearly was not caused or contributed to in any fashion by coal dust exposure." Dr. Rosenberg stated that: 1) the miner did not have medical or legal CWP; 2) he was severely disabled from a respiratory perspective, which was consequent to the presence of smoking-related COPD; 3) his COPD was not caused or hastened by the past inhalation of coal mine dust exposure; and 4) his death was not caused, hastened by or contributed to in any fashion by coal dust exposure or the presence of CWP. In Dr. Rosenberg's opinion, the miner's "terminal event was probably an acute myocardial infarction or heart attack, which led to respiratory failure. And because his lungs were so bad from his smoking-related COPD, he died with respiratory failure and couldn't get off the ventilator and subsequently expired." (EX 1).

On January 5, 2005, Dr. Rosenberg was deposed concerning his 2004 report. (EX 10). Again, Dr. Rosenberg noted a thirty-two year coal mining history, a "significant" smoking history of approximately thirty pack years, and a history of severe coronary artery disease along with severe pulmonary function impairment. He reiterated his finding of "very significant degree of what we call centribular emphysema" which he did not associate with the miner's coal dust exposure. Dr. Rosenberg described the studies he relied upon to show little or no relationship between coal dust exposure and advanced emphysema. He applied these studies to the miner's case in support of his opinion that the miner's exposure did not contribute to his emphysema. Dr. Rosenberg testified that he believed the miner had "minimal" coal workers' pneumoconiosis and did suffer from a totally disabling respiratory disease that contributed to and hastened the miner's death. However, he believed the COPD was caused by the miner's cigarette smoking rather than exposure to coal mine dust.

Other Hospital Records

The record contains a number of hospital progress notes from 1993 through 1997, authored by other physicians who saw the miner during his visits, including Drs. Ruiz, Schweigerdt and Candala. These doctors noted the patient's coronary artery disease, thirty year smoking history, COPD, chronic cholecystitis, unstable angina and frequent acute respiratory failure. (EX 8).

DISCUSSION AND APPLICABLE LAW

Because Claimant filed her application for survivor's benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, Claimant must establish by a preponderance of the evidence that the miner had pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that his death was due to pneumoconiosis. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-88 (1993). Failure to establish any of these elements precludes entitlement to benefits.

Pneumoconiosis and Causation

The regulatory provisions at 20 C.F.R. § 718.201 provide the following concerning the definition of "pneumoconiosis":

> (a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or

pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). However, the most recent x-ray evidence submitted as evidence by either party consists of two negative interpretations of films taken in 1984, thirteen years prior to the miner's death. Because of the age of the films, I give these x-rays little probative value in determining whether the miner suffered from pneumoconiosis at the time of his death. I rely principally on the other medical evidence of record, specifically the autopsy evidence and medical opinion evidence described below.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy or autopsy evidence. The Board has recognized that autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). *See also Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001). In this case, the original prosector's report was not offered as evidence by either party, but each party submitted a medical opinion by physicians who reviewed the autopsy slides and report. Dr. Perper, a board-certified pathologist, reported that the autopsy slides and report revealed a slight to moderate degree of pneumoconiosis as shown by macronodules in the lungs. Dr. Oesterling, also a board-certified pathologist, found "isolated" micronodular coal workers' pneumoconiosis, as shown by anthracotic pigmentation with focal micronodular pleural change. Although Dr. Rosenberg did not review the autopsy slides, he reviewed the autopsy report and Dr. Oesterling's report. At one point in his written report and in his deposition, Dr. Rosenberg agreed with Dr. Oesterling that the evidence supported a finding of "minimal" coal workers' pneumoconiosis. However, in his final written conclusions, Dr. Rosenberg reported that "Mr. Stewart did not have medical or legal CWP." Except for Dr. Rosenberg's inconsistent report, there is no dispute among the doctors that the autopsy evidence revealed at least simple pneumoconiosis. Therefore, I find that Claimant has shown that her husband suffered from pneumoconiosis pursuant to Section 718.202(a)(2).

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1,

1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove the existence of pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director*, OWCP, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 BLR 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982).

Dr. Kander, who treated the miner between 1991 and the miner's death in 1997 had "no doubt" that the miner's prolonged exposure to coal dust over the years "was some of the cause for his severe lung disease." Likewise, Dr. Haggenjos, who was also one of the miner's long-time treating physicians, found the existence of coal workers' pneumoconiosis. These two physicians were most familiar with the miner's condition and Dr. Kander, in particular, would have been very familiar with the miner's respiratory condition at the time of his death, having observed the deterioration of his respiratory and overall health at the crucial time in question. The amended regulations permit a fact-finder to assign greater weight to a treating physician's most recent opinion if the opinion meets the criteria for doing so as set forth in 20 C.F.R. § 725.104(d)(2001). As revealed by the progress notes, by Claimant's testimony, and by the doctors' own reports, Dr. Kander and Dr. Haggenjos treated the miner for his respiratory condition, along with his other ailments, meeting the criteria set forth in Section 725.104(d)(1). The record supports these doctors' statements and Claimant's testimony that they treated the miner and that Dr. Kander attended to the miner during his final hospitalization and at time of his death. Previously, Dr. Kander had treated the miner for about seven years and Mr. Haggenjos

treated him for over seventeen years. Therefore, their opinions are entitled to great deference. Both doctors saw the miner on a consistent basis, meeting the criteria for having a superior understanding of the miner's condition, as set forth in Sections 725.104(d)(2) and (d)(3). After observing and testing the patient during regular and emergency visits, these doctors prescribed medication and oxygen to help the patient's pulmonary difficulties. This factor meets the regulatory requirement that sufficient testing, examination and treatment be established by the evidence to afford these treating physicians' opinions greater probative weight under Section 725.104(d)(4).

Further, I find the opinions of Drs. Haggenjos and Kander to be well-reasoned and documented, meeting the criteria for assigning controlling weight to their opinions as set forth in § 725.104(d)(5). The opinions and notes of each of these doctors set forth the clinical findings, observations, facts and other data on which each physician based their diagnoses. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984). Moreover, their opinions are "reasoned," with underlying documentation adequate to support each physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). The opinions of record by Drs. Haggenjos and Kander are supported by their lengthy progress notes and explanation of the miner's condition at various times during his treatment with them and, in Dr. Kander's case, a well-reasoned explanation of the miner's condition immediately prior to death. *See also Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001). *See also Soubik v. Director, OWCP*, 366 F.3d 226 (3rd Cir. 2004). Therefore, I assign the greatest probative weight to the opinions of these two doctors that the miner suffered from clinical and legal pneumoconiosis.

As stated above, Drs. Perper and Oesterling found at least minimal pneumoconiosis. Therefore, these two opinions support those of Drs. Haggenjos and Kander that the miner suffered from pneumoconiosis at the time of death. Dr. Rosenberg's opinion is equivocal in that he reported a finding of a minimal degree of pneumoconiosis, but also wrote that Mr. Stewart did not suffer from legal or clinical pneumoconiosis. Therefore, I assign less probative weight to Dr. Rosenberg's opinion on this issue. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984). Based on the medical reports of the miner's treating physicians and the two board-certified pathologists, Drs. Perper and Oesterling, I find that Claimant has shown the existence of pneumoconiosis under Section 718.202(a)(4) by a preponderance of the evidence.

Pneumoconiosis Arising Out of Coal Mine Employment

Once it is determined that the miner suffered from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). Because Claimant has established that the miner had over ten years of coal mine employment, she is entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mine employment. *See* 20 C.F.R. § 718.203(b). This

presumption may be rebutted by evidence demonstrating another cause for the miner's pneumoconiosis. The Employer has proffered no evidence to show another cause for the miner's pneumoconiosis. Accordingly, I find that the miner's pneumoconiosis arose out of his coal mine employment.

Death Due to Pneumoconiosis

As noted, above, Claimant must present one of the following before being entitled to survivor's benefits: (1) competent medical evidence establishing that the miner's death was due to pneumoconiosis; (2) evidence showing that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) proof that the presumption set forth at 20 CFR § 718.304 applies, i.e., an irrebuttable presumption that death was due to pneumoconiosis where there is medical evidence of complicated pneumoconiosis. Because the record contains no evidence of complicated pneumoconiosis, the presumption under Section 718.304 is not available.

As a result of the above analysis surrounding the medical opinion evidence, I assign significant weight to Dr. Kander's listing on the Death Certificate that black lung disease was a contributing cause to the miner's death. I also assign great probative weight to Dr. Kander's final hospitalization report, describing the miner's deteriorating respiratory condition immediately prior to his death and explaining that the miner's past coal dust exposure "clearly" contributed to his demise. Because of Dr. Haggenjos' familiarity with the patient's condition for over seventeen years, I also assign significant probative weight to his opinion that coal worker's pneumoconiosis hastened the miner's death by exacerbating his COPD and compromising his heart and blood pressure.

Dr. Perper, a specialist in pathology, also produced a well-reasoned and documented report. His opinion is entitled to significant probative weight, as an expert in the field of observing autopsy evidence. *See Scott v. Mason Coal Co.,* 14 BLR 1-37 (1990) (en banc recon.); *Clark*, 12 BLR 1-149; *Fields*, 10 BLR 1-19; *Burns v. Director, OWCP*, 7 BLR 1-597 (1984). Dr. Perper provided an adequate and detailed explanation for his unequivocal opinion that pneumoconiosis hastened the miner's death, as set forth verbatim, above. Dr. Perper then referred to several medical studies supporting his statements, which he attached to his report.

Dr. Oesterling, while admitting that the miner had evidence of pneumoconiosis from the autopsy results, nevertheless believed that this "isolated" pneumoconiosis in no way hastened the miner's death. In support of this belief, Dr. Oesterling cited several studies that refuted medical theories propounded by Dr. Perper in support of his opposing opinion surrounding the etiology of the miner's lung disease. In arriving at his conclusion, Dr. Oesterling refused to rely on a coal history of thirty-two to thirty-eight years, as reported by the Claimant and established by the record, because he did not find coal deposits in the miner's lungs that would "substantiate" this lengthy coal dust exposure. Instead, Dr. Oesterling believed that the only contributors to the miner's death were the patient's coronary artery disease, a recent stroke, and subsequent arrhythmia. Dr. Oesterling recognized a severe disabling cardiopulmonary condition at the time of death, but disagreed with the statement on the Death Certificate that pneumoconiosis was a contributing cause of death or a factor contributing to the miner's undisputed emphysema. I

assign less probative weight to Dr. Oesterling's report because he did not accept the lengthy coal mine employment history that has been established and stipulated by the parties. *See Worhach v. Director, OWCP,* 17 B.L.R. 1-105 (1993)(per curiam). As a result, Dr. Oesterling's opinion is less reliable, as it is based on a less-accurate occupational history as compared to the miner's smoking history.

Likewise, Dr. Rosenberg's opinion is less reasoned and reliable, in that he first reported the existence of simple pneumoconiosis, but then concluded that the miner had no medical or legal pneumoconiosis. For the same reasons described above, I find this inconsistent opinion entitled to less probative weight on the issue of whether the miner's death was caused by pneumoconiosis, since it is unclear whether this physician believed the miner suffered from pneumoconiosis at all, as has been established by the autopsy evidence and the most probative medical opinions. *See Toler v. Eastern Assoc. Coal Co.*, 43 F.3c 109 (4th Cir. 1995); *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005)(unpub.). *See also Soubik v. Director, OWCP,* 336 F.3d 226 (3rd Cir. 2004).

The fact that the miner's pneumoconiosis was not the sole cause of death listed on the Death Certificate does not detract from the worthy opinions of the doctors who found that pneumoconiosis was a contributing cause. The regulatory standard is whether the miner's pneumoconiosis "hastened" the miner's death, as set forth in Section 718.205(c)(5). The Department of Labor specifically addressed this standard and the intended burden of proof in promulgating the amended regulations:

> ….the Department also rejects one commenter's position that the BLBA requires a "direct cause and effect relationship" between the miner's pneumoconiosis and death in order for a survivor to be entitled to benefits, at least insofar as the commenter would require that pneumoconiosis be the immediate, sole and proximate cause of the miner's death. Pneumoconiosis may be the direct, or proximate, cause of a miner's death (§ 718.205(c)(1)), but entitlements may also be premised on the lesser "hastening death" standard (§ 718.205(c)(2), (5))….The Department's interpretation reflects Congressional intent that benefits be awarded if the survivor establishes that pneumoconiosis was a contributing cause of the miner's death, although not the sole and immediate cause

65 Fed. Reg. 79,920; 79,950 (Dec. 20, 2000). There is no dispute among the doctors that the miner had an advanced pulmonary disease at the time of his death. The disagreement arises as to the etiology of the disease and the type of disease present. Although Drs. Kander, Haggenjos and Perper believed that coal dust exposure contributed to the miner significant and disabling pulmonary condition and hastened the miner's death, Drs. Oesterling and Rosenberg stated that coal mine dust was never a factor in the development of the miner's chronic obstructive disease or emphysema, and therefore, it could not have had an impact on his pulmonary function or shortened the miner's life. However, given the weight I have assigned to the opinions of the treating physicians, along with Dr. Perper's well-reasoned opinion, and the lesser probative value I have assigned to the opinions of Drs. Oesterling and Rosenberg, I find that the weight of the medical opinions surrounding causation of the miner's death meets the Claimant's burden of proof in this case. Therefore, Claimant has shown, by the preponderance of the medical opinion

evidence, the miner's death was due to pneumoconiosis as defined under the regulations set forth in Section 718.205(c).

ENTITLEMENT

Claimant has shown that the miner suffered from pneumoconiosis, that his pneumoconiosis arose out of his past coal mining employment, and that his death was due to pneumoconiosis. Therefore, Claimant is entitled to benefits beginning January 1, 1997, the month of the miner's death. 20 C.F.R. § 725.503(c).

Attorney's Fees

No award of attorney's fees for service to Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application. *Bankes v. Director*, 8 BLR 2-1 (1985). The application must conform to 20 C.F.R. § 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge Claimant any fee in the absence of the approval of such application.

ORDER

It is HEREBY ORDERED that:

1. The claim for benefits of Wanda Stewart under the Act is hereby GRANTED;

2. The Employer shall pay Wanda Stewart all benefits to which she is entitled under the Act, beginning January 1997;

3. The Employer shall pay Claimant's attorney fees and expenses to be established in a supplemental decision and order.

A

JOSEPH E. KANE
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).